Telephone interview with Dr. Howard Sirak, surgeon during the Korean War. Conducted by Jan K. Herman, Historian, Bureau of Medicine and Surgery, 17 January 2001.

Where did you go to medical school?
Ohio State University.

Are you from Ohio originally?
I'm originally from Cleveland.

When did you graduate from medical school?
In '47.

Were you in the V-12 program?
Yes I was. I enlisted in the predecessor to the V-12 program. I enlisted in the Navy in 1939 and they allowed me to finish my pre-med and medical school and then, of course, they snatched me up when the Chinese came across the border.

You didn't go in right at the beginning of the war; it must have been a little bit later in November or December of '50.
I was called in shortly after the onset of the Korean War and was stationed in Columbus. When the Chinese came across the Yalu in November, I was sent overseas.

The war started in June of '50 and the Chosin Reservoir withdrawal was going on in November and December of '50, so was it right after that then?
Yes, because I know that I was in Korea on Christmas day.

How did you get there?
Airplane, via Fairbanks and Shemya (Aleutians). They sent us over there on "Proceed Without Delay" orders. They needed surgical personnel to reinforce hospital units like Easy Med and Able Med, mobile, tented hospital units in the field attached to the 1st Marine Division.

Had you had much surgical experience before you went?
A couple of years. I was in residency at Ohio State University under Robert Zollinger, and I went directly to Korea from there, in the middle of the program, as a matter of fact.

How did you find out that the Navy wanted you? Did they just send you a letter and say, "Guess what, you're going?"
Right. "Proceed without delay."

But you weren't in the Navy at that moment?
No, not actually on active duty. But I was in the Reserves.

You were going and there was no question about it; that was it.
Yes, that's right, "proceed without delay." I understand that means 3 days.

I know a lot of people who were in practice at that time, or had been in the V-12 and had gotten out when World War II was over. Then, suddenly, Korea occurred and it was time to pay back the Navy.

Exactly. Well I didn't mind it, actually. I did mind leaving my family and young baby daughter. I had an opportunity to do research at NIH (National Institutes of Health), but I didn't want to pull any strings. And so I went.

What were your impressions when you encountered Korea for the first time? Did you land at Kimpo?

Yes, we landed at Kimpo. The place was shell-pocked; the buildings were all bullet-pocked. All I remember that it was a cold, snowy, winter night and we were all heavily clothed. The natives, the poor devils, were on the roads, moving back. They were in sandals with feet bare. It was a very cold night. I thought they had a remarkable resistance to the cold and I admired their resilience.

They had already been moving around as refugees. This wasn't the first time they had to be taking off.

That's right.

This was the second time they had been forced to flee. When the North Koreans arrived in June they had to leave and head south. And then, of course, the offensive went on and things looked pretty good there for a while, until the Chinese came in and made it a whole new war. So this was the second time these natives ended up being refugees.

That's exactly right--a yo-yo situation.

So you were there in Kimpo and it was the middle of the night. You must have been pretty bewildered yourself.

Well, yes. Korea was a lot different then than it is now, I can tell you. It was just a very primitive country at the time.

Did you know what your job was going to be when you got there?

Our military was worried that the Chinese might swing to the coast, cut the troops off, pinning them against the coast at Inchon. There were tremendous tides there, and that would have made evacuation difficult. They put us on various ships at Inchon, but they didn't know exactly how they were going to use us at the time. Apparently, they didn't want to establish any medical camps because they didn't know what was going to happen with the Chinese driving south.

By the way, I saw that article on Dr. Litvin; he was in the Chosin campaign. I remember one time later we were back at the Yokosuka Naval Hospital. After the Chosin retreat, the evacuees flooded the Naval hospital at Yokosuka. I had never seen so many cases of gangrenous black feet, noses, and extremities.

Did you get to work on any of those people?

Yes, on their wounds, but there was not a lot you could do for the gangrene. It was mostly waiting to see how the gangrenous tissues would demarcate, to avoid taking more tissue than was necessary. So most of our time was spent redressing the gangrenous wounds and with the usual cases of hernias, circumcisions, appendectomies, etc.

I haven't really talked to anybody who treated any of those frostbitten people. . .

Well there wasn't much we could do. We waited for the gangrene to demarcate until it became clear how much had to be removed.

How could you tell?

After demarkation, it was easy to distinguish what as dead and what was vital. The dead tissue became black as coal.

You could actually see an actual line in the tissue?

Yes, there was a clear demarcation between the pink skin and the necrotic tissue. We had people coming over from the States who experimented with the use of cortisone to see if it would increase the circulation or diminish the amount of tissue lost. But that didn't work.

You must have seen a lot of those patients.

At one time we had over 5,000 frostbite cases in the hospital.

And these were all victims of the Chosin campaign?

Mostly. These wounded would have to lie where they fell in the freezing snow for many hours until they were found and evacuated.

So there were a lot of amputations, then?

Well, yes there were. But many were evacuated to hospitals in the States or Hawaii if a longer interval was needed for demarcation to take place.

While you were waiting for these cases to demarcate and you decided on a treatment, were the patients kept in an area which was cooler? Was there any special treatment?

No, they were kept at normal room temperature. The problem, of course, is that frostbite plugs up the vessels (the red cells would coagulate inside the arterioles) blocking the circulation to the part, causing death of the distal tissue.

Was it the blood cells that were clumping?

Yes. The arterioles are small, muscular walled vessels--the tiny ones--that are pre-capillary. And the cold, of course, would cause them to contract. The red cells would clump inside them so that the tissue beyond, unable to receive nourishment, became gangrenous.

So you saw a lot of those.

Yes I did! And, of course, many of these kids had other wounds. In those cases, the beginning of the treatment was begun at the Yokosuka Naval Hospital and completed elsewhere in the U.S.

Did you treat any casualties while you were at Inchon?

No, we didn't have to because, as you know, the Chinese made a cardinal mistake and didn't attempt to pin the Marines and the Army against the coast around Inchon. Instead, our armies were able to retreat to Pusan. There were no fights. They just retreated in fairly orderly

fashion until they could form a strong perimeter in the south. So there weren't many casualties because the worst case scenario didn't happen. Thus, we wound up back in Yokosuka and stayed there until our armies began to push the enemy back north. When the Marines went on the offensive, the casualties poured in.

Do you recall what unit you were assigned to there?

The first time I was assigned to Able Med. Then the Marines went into reserve. When the Marines again went back on the assault, they reassigned me to Easy Med.

That would have been in '51 already.

That's right; it would have been '51. We had a lot of work to do in Easy Med when the Marines went back on the assault.

So, then you went back and forth from Japan to Korea.

We were back and forth several times. Every time the Marines went on reserve they would send us back to Yokosuka. And then as soon as the Marines were about to go back on assault they would fly us back to Korea. Easy Med and Able Med were the two to which our team was assigned.

Do you recall where Easy Med was located?

It was pretty far north situated along the Soyang River. It was the furthest north definitive medical unit. We got the casualties right off the field, after the corpsmen in the forward aid stations gave them plasma, and stopped the bleeding so that they could evacuate them to us. There was a tiny air strip adjacent to our camp, where the helicopters and sometimes the P-51s landed. The casualties would pour in, brought by DUKWs (amphibious trucks), helicopters with stretchers on the skids on each side, or by ambulances.

Do you recall what Easy Med looked like?

There were sleeping and supply tents and storage tents, but the unit was kept small so that it could be very mobile. We had tents with what I used to call "wall to wall carpeting" because it was all rice paddy that had been bulldozed flat. We had an operating room tent and a triage tent attached to it. This triage area was where the casualties were first brought to be assessed, transfused, and have their bloody clothing removed and searched for explosives. The clothing was thrown into a bonfire. Once, a grenade was overlooked.

What happened?

It was quite an explosion and we could hear the shrapnel go whistling over our heads. Luckily, no one was injured.

Let me see if I have the sequence correct. You would bring them into this particular tent, strip their clothes off, and then they would be triaged? This is where the triage took place?

Yes, that's right. We would have to make a decision whether a given wounded was salvageable. When the Marines were on the assault, we would be swamped with wounded. We had to direct our efforts to those who could be saved, so we had to make decisions about who would go into the operating tent in what order of priority.

So, let's say you'd get somebody who had an abdominal wound. They would go from that triage tent where they would get cleaned up and where the decision was made . . .

They were transfused, examined, and cleaned up as best we could.

And then they would go to the OR. . .

They would come into the OR and we would just go to work. One time I and my team operated 32 straight hours without eating or sleeping because the patient load was so enormous. The nights and days seemed to blend imperceptibly.

What kind of team would you have in the OR?

We had a good anesthesiologist whom I talked into coming over from the Yokosuka Naval Hospital. You needed a really good anesthesiologist and good anesthesia equipment. When we first went over there we took with us a whole lot of gear--a box as big as a coffin. I don't know how many hundred pounds it weighed. It was flown over. The first time we thought we were going to find good equipment when we opened it, unfortunately, it was filled with equipment, none of which we could use. There was stuff as outdated as Mercurochrome (merbromin), components that had to be hand-mixed to make a plaster cast.
We found drip ether and masks that dated to World War I! Well, you can't operate on young men with equipment that was obsolete.

This was all old stuff left over from the war?

Old stuff left from World War I. Who in 1950 remembers using Mercurochrome? Well, I remember it because I was born in the '20s and my mother would dab some on my scratches. But by 1950 it was a totally obsolete drug. We were so angry and disappointed that we had been supplied with junk and had been made to bring it all the way from Yokosuka, that we took all of this useless material and threw it into a rice paddy.

What about the anesthesia machine? Did you finally get one?

I remember the chief medical officer was a four-striper by the name of Butler, a captain stationed in Tokyo. When I was in Yokosuka, my anesthesiologist--my first assistant, Lew Burkley--and I went to talk to him. We were only lieutenants--two stripers-- and we told him that we had to have a decent anesthesia machine. His rejoinder to me was "Can't you just drip a little ether?" But I think he or CAPT Leo Potter at the hospital was the one who finally helped us get a good machine.

He eventually got you a machine?

He either did or someone just "borrowed" it from somewhere; I don't know. Anyway, somehow we got a good anesthesia machine. I got a fine anesthesiologist, Max Butler. I also had a good first assistant, Lew Burkley. He was an OB/GYN man.

Did you have suction? Did you have what you needed?

Yes. We had suction. We had malleable retractors made by the men in the nearby engineering camp who split some copper tubing longitudinally, and flattened it. They hadn't supplied those to us.

How about operating lamps?
Yes. We had good lights.

Did you have any x-ray at all?
No.

That was one of the big complaints that I heard.
We didn't have any x-ray equipment up there. All the power there came from generators. No. We didn't have any x-ray machines.

That made things pretty complicated for locating fragments, didn't it?
Yes it did. But the main thing was to solve the problems with the holes or tears in the gut, or in the chest, and to control bleeding. Those were the main things we had to do.

Did you do any vascular surgery at all? Did you ever experiment doing it?
No, we didn't experiment. We did repair arterial tears if they were repairable. We didn't have [artificial] grafts in those days and they probably would not have been suitable because you had to deal with dirty wounds--contaminated wounds. If you used a foreign body (a prosthetic graft), your chances of success would be small.

How about arterial anastomoses?
That I did. If you had somebody with a lacerated carotid I could repair it.

No, I know I had talked with an Army surgeon who was at one of the MASH's there and he told me it was Army policy that they weren't allowed to play around with any of that as far as limbs. If a limb wasn't getting a blood supply, that was it. It was amputated, which was pretty much the way things were in World War II. Things hadn't really advanced very far. However, there were some physicians who would play around with vascular repair back in the States at their civilian hospitals. But by doing it in the MASH, they violated Army regulations. Even so, they were achieving some success with it.
The problems were what I just said. Actually, we were required to do guillotine amputations instead of making a flap. We saw a lot of wounded where the extremity from the knee down would be completely shattered. There was no saving these.

Because of the dirty. . .
The risk of infection, yes.

They would take care of that back in Japan.
Yes, or at another hospital facility later on.

This particular case, Fenwick. I don't know if you remember it. I looked at one page of his medical record and it indicated that he had six gunshot wounds of the mid-section and flank. He remembers coming into a tent where there was a wooden table. That must have been in the room you were talking about, the triage tent. He says he remembers coming in badly wounded and in pain. He recalls them cutting his clothes off, moving him into another tent, and remembers you and another surgeon coming in. He says you were

very comforting and that you said he was going to be okay and that you were going to do the best you could to take care of him. You made a motion with your finger on his abdomen and said you were going to make a little incision to do a little exploring to see what was going on . . .

(Laughing)

And of course when he woke up he had an incision from his pubic bone up to his chest. The wounds of entry were in his abdomen and they exited his back.

Yes, he was a lucky one. We may have had to take out his spleen; I don't remember if that was done or not, but I know he probably would have had multiple holes throughout his intestines

Well, he says he remembers you telling him afterward that you had gone in and repaired his intestine and he had something like 750 sutures. So, you were obviously working on him for a long time.

Oh yes. You must be very careful not to overlook a small perforation in the gut or a laceration of a major blood vessel. You may get only one crack at them. If they continue to spill feces into their peritoneal cavity, they will likely dir or have serious complications. It is necessary to "run" the bowel from one end to the other and check all the organs and retroperitoneal area.

Apparently, he was also lucky that none of the projectiles touched his . . .

Aorta, vena cava, or spine..

And, although all the bullets had missed his spinal cord, he was numb from the waist down. He remembers someone calling it spinal shock.

He may very well have had a near miss of his spinal column with resultant edema in the cord.

But you said to him afterward that the numbness in his legs would probably go away which it eventually it did. So he wasn't paralyzed, fortunately.

He's one lucky stiff.

Yes, he's walking around today.

Yes?

Thanks to you. . .

(Laughs) Well there were a lot of other fellows who contributed greatly. The forward aid stations' doctors and corpsmen, my first assistant and anesthesiologist, and, certainly, our 12 corpsmen.

He remembered your name very specifically, which I thought was pretty remarkable in the condition he was in. He couldn't remember how to spell it, but I said are you sure it was Sirak and he said "Absolutely. I have no doubt about it because I remember talking to him before and after the surgery." And you had told him exactly

what you had done to him, what you had resected and everything. As you say he is one lucky guy to be alive today.

Yes. I was telling my son John the story. He is finishing up in heart surgery, which is what I did. He asked, "In those days you didn't have a sewing clamp did you?" I laughed. It wasn't invented yet. If we had trouble getting a good anesthesia machine and malleable retractors, I doubt we would have gotten a fancy instrument like a sewing clamp, even if it were available.

A sewing clamp?

It's a kind of clamp you put on. It's like a stapler and it puts in staples which puts the bowel together easily and quickly. You don't have to put in a bunch of sutures to put the bowel back together. In those days it wasn't available.

So everything was sutures?

Everything was repaired with sutures.

What kind of sutures did you use?

Cat gut, an absorbable suture. We worried about using a foreign body in a contaminated area. Remember, you had no time preoperatively to use intestinal antibiotics to reduce the bacterial flora like you would if you were doing an elective procedure on a patient here in the States. You always had to be concerned about infection. Silk, of course, is a foreign body so we didn't use any except for vascular repairs.

So you wouldn't have to go in and remove sutures.

That's right. If they developed an abscess, they would have required re-operation and that would increase the patient's risk. Laparoscopy didn't exist.

What would you have had for antibiotics?

We had antibiotics. We had chloramphenicol, which was later eliminated because of its toxic effect on the bone marrow. We also had streptomycin, terramycin, and penicillin.

Did you have Aureomycin?

I can't remember if we did or not.

Penicillin was available then.

Yes. We had penicillin and sulfas.

What kind of anesthesia would you have used?

We had a very good anesthesiologist, and he had a good enough machine so that we could put these kids to sleep safely and still get good relaxation of the abdominal muscles.

Did you use pentothal?

I think he may have used a little pentothal for induction, but not to carry the patient during the procedure. You don't get enough abdominal muscular relaxation with pentothal. And if you give too much, then you have post-operative problems. I can't remember what

inhalational anesthesia we used, but it would have been one of the commonly used inhalational types.

How long were you at Easy Med?
Several weeks.

And you saw a lot of surgery in those several weeks, probably enough to last you your entire life.
More dirty bellies than I care to see again. There usually were cinders, gravel, grass, clothing, and other foreign material that would be blown into and through the abdominal wall. This made the skin a difficult surface to render sterile.

That was probably quite an experience. You probably haven't thought about it in 50 years.
I really haven't very much. I think it's one of those things that the mind purposely blanks out. When you carry a youngster into an operating tent screaming "Don't let me die! Don't let me die!"that makes an indelible impression on you.

When I talked to Fenwick the other day, and he told me that you had saved his life and that he was grateful, I got to thinking that you and other surgeons in Korea never really knew the outcome of many of these cases.
That's right. That's right, I never did. A lot of them were evacuated directly back to the States, or they might have been evacuated to a hospital ship and then back to the States.

How long would they be with you, for example?
Until they were stable. We made the decision as to whether they could be safely moved or not. And if a man was still "rocky" he would stay with us until he stabilized well enough to be safely transported.

Did you have any nurses at Easy Med?
No, we just had corpsmen. The Army had nurses.

The MASH's were probably better equipped then you all were.
I guess they were. We occasionally went down to the MASH unit which was quite a distance south on the MSR (main supply route) to get a good shower. We had showers but they weren't as nice as those in the Army. The Army had wooden decks, linen table cloths, and were served their meals at the dinner table.

And your conditions were a bit more primitive?
We didn't mind it. We were actually quite proud of it because we thought that, being closer to the lines, the wounded got to us sooner. It didn't affect our work or morale.

That fact that you could work miracles with nothing.
Because we were smaller and more mobile, we could be closer to the lines. The wounded didn't have that extra hour drive down the MSR or a longer flight down to the Army MASH units.

You were pretty close to the lines then.

I don't remember how many miles from the line we were. All I know is that at Easy Med we had some 105 mm "Long Toms" about hundred yards from our operating tent that were firing into the Korean positions north. So we weren't too far behind the lines if they were firing those because they wouldn't dare be too far, lest they produce some short rounds that would injure our own men.

How many months were you there?

I guess I was in Korea, and back and forth from Yokosuka for 14 months.

Well, there's at least one patient you know did well.

Yes he did. I sure would like to know about some of the others. Somewhere up in the attic I may still have copies of all my operating reports.

This event took place in October of 1951. He was wounded, I want to say the 5th or the 8th of October of '51. If you ever find those records you might be able to correlate that.

I will go up there in the next day or two and check it out.

His name was John Fenwick.

Fenwick? I remember. I have it written down.

If you find it that would be quite remarkable.

Yes, it certainly would.

I think it is remarkable that I found the patient, the corpsmen, and now I found the surgeon who worked on him. After 50 years that is pretty remarkable in itself.

Who is the corpsman?

His name is Glen Snowden.

Oh, I remember him.

You do?

I remember Glen, yes.

In fact, you may have been treating him at Easy Med because he was wounded the same day in the act of saving Fenwick. He was hit in the upper arm.

Well, that's right. I remember treating some corpsmen, and Snowden sort of rings a very vague bell. He would have come down at the same time, you see. He's the guy who deserves the credit. He obviously went out under fire and pulled Fenwick in.

He eventually lost his arm as the result of that wound.

Is that right?

It might be interesting to find his medical record and see what happened. But he was wounded in the act of saving Fenwick.

Well, he would have been there if he had been wounded in the same action.

Snowden is kind of an interesting fellow. He mentioned that what he used to do was get pieces of limb from a tree and whittle the bark off, then put these things in his pocket like plugs. Then, if he was wounded he would just take one of these things and push it in the wound and it would stop the bleeding.

Good Lord!

I had never heard of that before.

Amazing! The problem with that method is that it would work only with the entry wound.

It wouldn't work in an exit wound very well because the hole would be much larger.

Oh, it would be enormous. We would see men that would have an entry wound on the inside of the thigh or on the outside of the thigh. And the entire side of the thigh opposite the entry wound, from knee to groin, would be gone because the projectile would hit the bone and the shattered bone would become secondary missiles. There would be little soft tissue left. And if you looked at just the entry side, you would say it was just a small hole.

Apparently, with Fenwick's wounds, the bullets came in the front and exited from the back. According to his memory, a fist-sized exit wound came out his back and that's what Snowden remembers plugging with a skivvy shirt held in place by a battle dressing wrapped around Fenwick's body to stem the hemorrhage. He must of lost a tremendous amount of blood on the way back.

I would think. But like I say, if he had had to go another significant distance. . . If he were evacuated from the front lines in a DUKW, he might not have made it. Or if we were further back . . . That's the point I was making earlier.

Well, they got him on a chopper, and that's probably why he survived.

That's undoubtedly why he survived. The wounded would be brought to us in any kind of vehicle that was available when the casualties became so numerous during a Marine assault. We even had some Chinese who were captured and were brought in. They would look in complete wonderment at how much equipment we had. Of course, I didn't think we had that much. Remember, we had to make some of own retractors and we had no x-ray.

Not having an x-ray was probably a real deficiency. I know some of the other surgeons I talked to mentioned the fact that they had no x-ray at all. There was always a fear that there were fragments they missed. In some cases they did miss fragments and that caused real problems.

Although, in a circumstance like that when you have a massive belly wound. If you've got fragments buried in soft tissue, let's say in the back or even the abdominal wall, depending upon where the piece of shrapnel was located, you wouldn't go digging for it anyway. Unless the shrapnel was easily available, it's better not to make another wound that could become infected. Under field conditions, one shouldn't make a bigger or additional wounds. Subsequent infection was always a threat when dealing with a contaminated operative field. Believe me, they were "dirty" bodies! As I said earlier, there was usual "rice paddy", clothing, cinders, and other debris driven into the skin and tissues by the explosion or impact.

Did you ever get an x-ray machine while you were at Easy Med?

No. That would be most useful in assessing chest wounds. What we really wanted were really top notch anesthesiologists and equipment.

And you got both. Do you remember the name of your anesthesiologist?

Oh yes. His name was Max Butler. He died about 20 years ago.

We were woefully unprepared for that whole situation--Korea. Every story I've heard from surgeons like yourself or anybody who was thrown into that mess says the same thing. You all had to make do as best as you could with what you had.

That's right.

Dr. Sirak, I want to thank you for sharing all this with me.

You're very welcome.